| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155287 | A. BUILDING 00<br>B. WING | 08/08/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RENSSELAER CARE CENTER | 1309 E GRACE ST<br>RENSSELAER, IN47978 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates:<br>August 1, 2, 3, 4, 5, and 8, 2011<br><br>Facility number: 000185<br>Provider number: 155287<br>AIM number: 100290840<br><br>Survey team:<br>Regina Sanders, RN, TC<br>Heather Tuttle, RN (August 2, 3, 4, and 5, 2011)<br>Lara Richards, RN (August 2, 3, 4, and 5, 2011)<br>Kitty Vargas, RN (August 2, 3, 4, and 5, 2011)<br><br>Census bed type:<br>SNF/NF: 107<br>Total: 107<br><br>Census Payor type:<br>Medicare: 14<br>Medicaid: 76<br>Other: 17<br>Total: 107<br><br>Sample: 22<br>Supplemental sample: 1 | F0000 | 8.22.11This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Please accept this plan as our credible allegation of compliance. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review 8/10/11 by Suzanne Williams, RN | | | |
| F0157<br>SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>Based on record review and interview, the facility failed to notify residents' physicians of low blood sugar results for | F0157 | **F 157**<br>**1.**<br>**Corrective action**<br>For resident 24 and 36 physicians were notified regarding low blood | 08/31/2011 |

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| | 2 of 7 residents with glucometer (blood sugar) checks in a sample of 22. (Residents #24 and #36)<br><br>Findings include:<br><br>1. Resident #36's record was reviewed on 08/01/11 at 4 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.<br><br>The Physician's Recapitulation Orders, dated 08/11, indicated an order, which originated on 06/16/11, to administer a glucometer check (blood sugar check) four times daily, before meals and at bedtime and to call the physician if the blood sugar was less than 60 or more than 400.<br><br>The resident's Nurses' Notes, dated 07/28/11 at 3:45 a.m., indicated the resident's blood sugar was 52 and orange juice was given, and after 15 minutes the blood sugar was 74.<br><br>There was a lack of documentation in the resident's Nurses' Notes and MAR to indicate the resident's physician had been notified of the low blood sugars.<br><br>During an interview on 08/02/11 at 10 a.m., LPN #1 indicated the physician had | | sugars. Resident 24 had physician notified on Aug 2 nd, 2011 and 36 physician was notified July 28 th , 2011, with documentation for both in regards to notification found in the clinical record.<br>**2. Identification of others potentially affected**<br>On August 19 th , 2011 a 100% audit was conducted for residents requiring accu checks by nursing management. No resident found to require MD notification. Blood sugars within parameters.<br>**3. Systemic changes**<br>In service with education provided to licensed nurses on 8.18.11 by staff development coordinator in regards to protocol parameters for MD notification of hypo/hyperglycema events with documentation in clinical records of this notification. Education will be ongoing and during orientation. Nursing staff will be in serviced by, 8.31.11.<br>**4. Quality Assurance**<br>**100% audit weekly X 4 weeks of accu check results then monthly X 6 months.**<br>**Continued need for audit will be determined thru PI process if greater then 95 % compliance noted at 6 months. Nursing administration will review resident's with change of condition ongoing during the clinical meeting, held Monday thru Friday during business hours, to ensure proper MD** | |

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| | not been notified of the low blood sugars. She indicated there was no documentation in the resident's record or on the South Units 24 hour report sheet to indicate the resident's physician had been notified.<br><br>2. Resident #24's record was reviewed on 08/02/11 at 10:25 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.<br><br>The Physician's Recapitulation Orders, dated 08/11, indicated an order, originally written on 03/08/11, to check the resident's blood sugar three times a day and to notify the physician if the blood sugar was less than 60 or more than 400.<br><br>The resident's MAR dated 07/11, indicated the resident's blood sugar at 7 a.m. on 07/12/11 was 48 and the 7 a.m. blood sugar on 07/26/11 was 57.<br><br>There was a lack of documentation on the MAR and in the Nurses' Notes to indicate the resident's physician had been notified of the low blood sugars.<br><br>During an interview on 08/02/11 at 1:50 p.m., the Director of Nursing indicated the physician had not been notified of the low blood sugars.<br><br>An undated facility policy, titled, | | **notification. Any non-compliance with physician notification found for resident' s receiving accu-checks thru audits or during clinical meetings will be corrected immediately by notifying the physician and re-education provided as needed.**<br>**5. Systemic Change/Completion Date**<br>8.31.11 | |

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| | "Changes in Resident's Condition or Status", received from the Assistant Director of Nursing on 08/03/11 at 2:55 p.m., indicated, "the facility will notify the resident, his/her attending physician...b. there is significant change in the resident's physical, mental, or emotional status...d. There is a need to alter the resident's treatment or medications significantly..."<br><br>3.1-5(a)(2)<br>3.1-5(a)(3) | | | |

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| F0225 SS=D | The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | | | |
| | Based on record review and interview, the facility failed to ensure all allegations of abuse were reported immediately to the Administrator for 1 of 4 allegations of abuse reviewed, for | F0225 | **F 2251. Corrective Action**CNA # 1 was educated to the abuse policy and appropriate notification procedure with corrective action applied on 7.25.11 by DON and ED. Neither resident # 29 nor # | 08/31/2011 |

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| | 2 of 3 residents reviewed for allegations of abuse in a sample of 22. (Resident #29 and #30)<br><br>Findings include:<br><br>Review of the allegation of physical abuse, dated 07/22/11, on 8/3/11 at 12:30 p.m., indicated CNA #1 made the allegation that CNA #2 was rough with Residents #29 and #30 while providing peri care. When the residents were questioned, they did not confirm the allegation. Resident #29 did have a bruise on her inner thigh but appeared to be older. Resident #30 did not have any bruising.<br><br>Review of the Witness Statements dated 7/21/11 (no time) indicated CNA #1 was in Resident #29 and #30's room on 7/21/11 during the 3-11 shift helping CNA #2 with incontinent care for both residents. CNA #1 indicated that CNA #2 was rough when moving her legs with Resident #30 while performing incontinence care. CNA #1 also indicated at the time, that while changing Resident #29 (Resident #30's roommate) she was digging her fingers into the resident's thighs and there were finger marks. The CNA also indicated Resident #29 stated at the time, that CNA #2 was | | 30 were affected due to DON being notified immediately. **2. identification of others potentially affected**3. systemic changesNursing staff to notify and chart that the administrator of the facility has been notified of the allegation. Policy and Procedure for abuse was updated to include Director of Nursing and Executive Director must be notified immediately. Quarterly reminder training of entire staff on the abuse and neglect policy with reporting system will be conducted by social services director/designee.Initial training by Social Services/SDC on the abuse policy with new associates during orientation including recognizing abuse, perception and proper reporting. Executive Director will manage suspected abuse allegations immediately following state and facility policies4. Quality AssuranceAllegations will be reviewed in inter disciplinary meeting held Mon thru Fri. during business hours. Abuse reporting and follow up actions added to monthly PI improvement meetings to monitor for trends and completeness5. Systemic Changes/Completion Date8.31.11 | |

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| | being rough with her. The witness statement from CNA #1 indicated the time of the incident occurred at shift change.<br><br>Review of the Witness Statement from CNA #2 dated 7/22/11 (no time) indicated that she had started her rounds at 9:30 p.m., and she did not do any walk through rounds with the midnight shift. The CNA indicated that Resident #30 had a bowel movement during last rounds and she had informed the midnight shift that she had been having them all day so that she was aware of it. She indicated that she did not say anything out of the way to the resident and she was not rough at all.<br><br>Interview with the Director of Nursing on 8/3/11 at 2:00 p.m., indicated the charge nurse had informed her of the incident at 3:00 a.m., when CNA #1 had made the allegation of physical abuse. The Director of Nursing indicated at the time, that she did not call the Administrator at that time. She indicated she informed the Administrator the next morning when he arrived to work.<br><br>Interview with the Administrator on 8/3/11 at 1:35 p.m., indicated he was made aware of the incident on | | | |

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| | 7/22/11 when he arrived to work.<br><br>3.1-28(c) | | | |
| F0226<br>SS=D | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br>Based on record review and interview, the facility failed to ensure their policy and procedures were followed for reporting and managing allegations of abuse related to immediately informing the Administrator of any allegations of abuse and immediately assessing the residents after allegations of abuse were made for 1 of 4 allegations of abuse reviewed, for 2 of 3 residents reviewed for allegations of abuse in a sample of 22. . (Residents #29 and #30)<br><br>Findings include:<br><br>Review of the updated 2/09 Policy for Reporting alleged abuse provided by the Administrator indicated all personnel are mandated to promptly report suspected resident abuse and/or neglect to their immediate supervisor and/or facility | F0226 | **F 226**1. Corrective Action CNA # 1 was educated To Abuse Policy with appropriate notification procedure with corrective action applied on 7.25.11 by DON and ED. Resident #29's chart was reviewed on 7.25.11 by DON and ED. Head to toe assessment was completed on 7/22/11 and in clinical record. Resident #30's chart was reviewed on 7.25.11 by DON/ED. Head to toe assessment was completed on 7/22/11 and in clinical record.**2. Identification of Others potentially affected**Since each resident could be at risk entire staff was in serviced by SDC/ED on 8.18.11 to proper notification procedures in regards to alleged abuse using our abuse policy and state guidelines and how to conduct head to toe assessments for any resident immediately after an allegation of abuse**3. systemic changes** Nursing staff to notify the administrator immediately if allegation of abuse | 08/31/2011 |

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| | representative. The person observing an incident of resident abuse or suspecting resident abuse will immediately report such incidents to their immediate supervisor and/or the charge nurse. The charge nurse will immediately assess the resident and offer medical attention, if necessary. Findings of the assessment and any treatment provided will be documented in the resident's medical record. When an incident of resident abuse is suspected, the incident must be reported to the supervisor regardless of the time lapse since the incident occurred. The supervisor notifies the director of nursing and executive director of the alleged incident<br><br>Review of the allegation of physical abuse, dated 07/22/11, on 8/3/11 at 12:30 p.m., CNA #1 made the allegation that CNA #2 was rough with Residents #29 and #30 while providing peri care. When the residents were questioned they did not confirm the allegation. Resident #29 did have a bruise on her inner thigh but appeared to be older. Resident #30 did not have any bruising.<br><br>Review of the Witness Statements dated 7/21/11 (no time) indicated CNA | | is made. Nurse on duty is to immediately do a head to toe assessment of the resident who makes the allegation of abuse. Policy and Procedure for abuse was updated to include Director of Nursing and Executive Director must be notified immediately. Quarterly reminder training of entire staff on the abuse and neglect policy with reporting system will be conducted by social services director/designee. Initial training by Social Services/designee on the abuse policy with new associates during orientation including recognizing abuse, perception and proper reporting. Executive Director will manage suspected abuse allegations immediately following state and facility policies**4. Quality Assurance**Allegations will be reviewed in inter disciplinary meeting held Mon thru Fri. during business hours. Abuse reporting and follow up actions added to monthly PI improvement meetings to monitor for trends and completeness**5. Systemic Change/Completion Date**8.31.11 | |

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| | #1 was in Resident #29 and #30's room on 7/21/11 during the 3-11 shift helping CNA #2 with incontinent care for both residents. CNA #1 indicated that CNA #2 was rough when moving her legs with Resident #30 while performing incontinence care. CNA #1 also indicated at the time, that while changing Resident #29 (Resident #30's roommate) she was digging her fingers into the resident's thighs and there were finger marks. The CNA also indicated Resident #29 stated at the time, that CNA #2 was being rough with her. The witness statement from CNA #1 indicated the time of the incident occurred at shift change.<br><br>Review of the Witness Statement from CNA #2 dated 7/22/11 (no time) indicated that she had started her rounds at 9:30 p.m., and she did not do any walk through rounds with the midnight shift. The CNA indicated that Resident #30 had a bowel movement during last rounds and she had informed the midnight shift that she had been having them all day so that she was aware of it. She indicated that she did not say anything out of the way to the resident and she was not rough at all.<br><br>The record for Resident #29 was | | | |

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| | reviewed on 8/2/11 at 2:30 p.m. Review of Nursing Progress Notes dated 7/22/11 at 10:15 a.m., indicated a head to toe assessment was completed for the resident.<br><br>The record for Resident #30 was reviewed on 8/2/11 at 1:20 p.m. Review of Nursing Progress Notes dated 7/22/11 at 1:00 p.m., indicated head to toe assessment completed.<br><br>Interview with the Director of Nursing on 8/3/11 at 2:00 p.m., indicated the charge nurse had informed her of the incident at 3:00 a.m., when CNA #1 had made the allegation of physical abuse. The Director of Nursing indicated at the time, that she did not call the Administrator at that time. She indicated she informed the Administrator the next morning when he arrived to work. Further interview with the Director of Nursing at the time, indicated a head to toe assessment for both residents was not completed immediately as per the abuse policy.<br><br>Interview with the Administrator on 8/3/11 at 1:35 p.m., indicated he was made aware of the incident on 7/22/11 when he arrived to work.<br><br>3.1-28(a) | | | |

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| F0246 SS=D | A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br>Based on observation and interview, the facility failed to ensure the resident's call light was positioned so that the resident could reach it and call for assistance, for 1 of 20 residents observed for call light placement in a sample of 22. (Resident #26)<br><br>Findings include:<br><br>1. Resident #26 was observed in bed on 8/2/11 at 9:10 a.m. The resident's call light was not within reach. The call light was on the chair that was next to the resident's bed.<br><br>The resident was observed on 8/3/11 at 8:25 a.m. He was in bed. The resident's call light was on the chair that was next to the resident's bed. It was not within his reach.<br><br>On 8/4/11 at 8:40 a.m., the resident was observed in bed. The call light was observed to be clipped to the resident's | F0246 | **F 157**<br>**1. Corrective action**<br><br>For resident 24 and 36 physicians were notified regarding low blood sugars. Resident 24 had physician notified on Aug 2 nd, 2011 and 36 physician was notified July 28 th , 2011, with documentation for both in regards to notification found in the clinical record.<br><br>**2. Identification of others potentially affected**<br><br>On August 19 th , 2011 a 100% audit was conducted for residents requiring accu checks by nursing management. No resident found to require MD notification. Blood sugars within parameters.<br><br>**3. Systemic changes** | 08/31/2011 |

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| | blanket, but the blanket and the call button were on the side of the bed out of the resident's reach. Interview with the resident at that time indicated he did not know where the call light was.<br><br>Interview with LPN #5 on 8/4/11 at 8:50 a.m. indicated the resident was capable of using the call light. She indicated the resident did use the call light to request assistance.<br><br>3.1-3(v)(1) | | In service with education provided to licensed nurses on 8.18.11 by staff development coordinator in regards to protocol parameters for MD notification of hypo/hyperglycema events with documentation in clinical records of this notification. Education will be ongoing and during orientation. Nursing staff will be in serviced by, 8.31.11.<br><br>4. Quality Assurance<br>100% audit weekly X 4 weeks of accu check results then monthly X 6 months. Continued need for audit will be determined thru PI process if greater then 95 % compliance noted at 6 months. Nursing administration will review resident's with change of condition ongoing during the clinical meeting, held Monday thru Friday during business hours, to ensure proper MD notification. Any non-compliance with physician notification found for resident's receiving accu-checks thru audits or during clinical meetings will | |

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| | | | be corrected immediately by notifying the physician and re-education provided as needed.<br><br>**5. Systemic Change/Completion Date**<br><br>8.31.11 | |
| F0253<br>SS=C | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>Based on observation and interviews, the facility failed to ensure the resident's environment was clean and in good repair related to marred and gouged doors, chipped paint, missing floor tiles, broken baseboard rail, and blistered plaster for 4 of 4 units and 1 of 3 dining rooms. This had the potential to affect 107 of the 107 residents residing in the facility. (East Unit, Special Care Unit, South Unit, West Unit and North Dining Room)<br><br>Findings include:<br><br>The following was observed during the Environmental Tour on 8/4/11 :<br><br>On the West Unit at 10:30 a.m.:<br><br>a. Room 407 had black marred areas on | F0253 | F 253<br>**Corrective Action**<br>Room 407 had door immediately painted, room 414 had chipped paint immediately fixed, shower room door and tile for West hall were immediately fixed, room 301 had marred door painted. South halls shower room had marred door fixed. Special care unit baseboard was immediately fixed. Room 113 had marred door immediately fixed. North dinning room wall, below window, had work completed immediately. Orders were initiated on 8.4.11 and work completed.<br>**Identification of others potentially affected.**<br>100% audit concerning environmental rounds in regards to paint and tile was conducted on 8.12.11 by maintenance supervisor and assistant.<br>**Systemic Changes** | 08/31/2011 |

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| | the bottom 18 inches of the closet door. Interview with the Housekeeping Supervisor at the time of tour, indicated 2 persons resided in the room.<br><br>b. Room 414 had chipped paint on the wall, 18 inches from the floor, between the bathroom and the closet door. Interview with the Housekeeping Supervisor at the time of tour, indicated 1 person resided in the room.<br><br>c. The door to the shower room had gouges on the door edge and the kickplate. There were 8 missing tiles on the shower room floor. Interview with the Housekeeping Supervisor on 8/4/11 at 11:45 a.m., indicated 26 resident used the West Unit shower room.<br><br>On the South Unit at 10:50 a.m.:<br><br>a. Room 301 had black marred areas on the bottom 18 inches of the door kickplate. Interview with the Housekeeping Supervisor at the time of tour, indicated 2 persons resided in the room.<br><br>b. The door to the shower room had black marred areas on the kickplate. Interview with the Housekeeping Supervisor on 8/4/11 at 11:45 a.m., indicated 31 persons resided on the South Unit and used the | | Mentioned areas placed on audit form and maintenance will round on indicated areas 1X per week for 12 weeks.<br>With forms monitored by Executive Director<br>**Quality Assurance**<br>Maintenance to do environmental rounds monthly and present in the PI committee. PI committee to determine if rounding should continue if after 2 quarters of 100% compliance has occurred.<br>**5.**<br>**Systemic change/completion date** | |

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| | shower room.<br><br>On the Special Care Unit at 11:00 a.m.:<br><br>a. There was a 6 inch piece of broken baseboard outside of the dining room. Interview with the Housekeeping Supervisor on 8/4/11 at 11:45 a.m., indicated 22 persons resided on the Special Care Unit.<br><br>On the East Hall at 11:15 a.m.:<br><br>a. Room 113 had black marred areas on the kickplate of the door. Interview with the Housekeeping Supervisor at the time of tour, indicated 2 persons resided in the room.<br><br>The North Dining Room was observed at 11:40 a.m. A 15 foot area of the wall below the window had plaster that was blistered and in need of repair. The area was 6 inches above the floor. Interview with the Housekeeping Supervisor at the time of tour, indicated 32 residents ate their meals in the North Dining Room.<br><br>Interview with the Maintenance Supervisor on 8/4/11 at the time of the tour, indicated all the above areas were in need of repair or cleaning.<br><br>3.1-19(f) | | | |

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| F0282 SS=E | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on observation, record review, and interview, the facility failed to ensure physician orders and the resident's current plan of care were followed related to bed and/or wheelchair sensory pad alarms, blood sugars, blood sugar protocol, dietary supplements, treatments for pressure sores, daily weights completed, medication administration, labs completed, and gradual dose reduction recommendations for 8 of 22 sampled residents reviewed for physician orders. (Residents #2, #4, #19, #24, #26, #36, #41, and #49)<br><br>Findings include:<br><br>1. On 8/2/11 at 9:10 a.m., Resident #41 was observed sitting on the side of her bed eating breakfast. At that time, there was no bed alarm observed on the bed.<br><br>The record for Resident #41 was reviewed on 8/2/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, history of falls, | F0282 | **F282 483.20(k)(3)(ii) Services By Qualified Persons/Per Care Plan 1. Corrective action** a. Resident #41, this resident no longer resides in this facility. b. Resident #49, fall interventions were reviewed on 8/19/11 and will be monitored as needed c. Resident #19, the physician was notified on 8/4/11 and new orders received to change blood sugar monitoring protocols to primary physician protocols. d. Resident #4, the physician was notified on 8/2/11 and new orders received to continue with Glucerna 3 times a day. The Yogurt order was clarified with the dietary department on 8/3/11 and is now on the resident's tray card and served with meals. e. Resident #26, the dressing to left inner heel was applied on 8/2/11 in front of surveyor f. Resident #2, the physician reviewed the resident's medical record and declines at this time to proceed with decrease in anti-anxiety medication on 8/3/11. The physician reviewed resident weights and current orders and discontinued the daily weights and I.M. Lasix on 8/3/11 due to resident weight stable. g. | 08/31/2011 |

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| | stroke, and diabetic neuropathy. The resident was admitted to the facility on 7/16/11 from the hospital.<br><br>Review of Physician orders dated 7/19/11 indicated sensory pad alarm to bed and wheelchair. Check placement and function every shift.<br><br>The current plan of care dated 7/25/11 indicated the resident had a history of multiple falls. The nursing intervention was to place a sensor pad alarm to bed and wheelchair.<br><br>Review of Nursing Progress Notes dated 7/29/11 at 1:00 a.m., indicated the resident was found lying on the floor in front of the bathroom door.<br><br>Review of the Incident Follow up and Recommendations Form provided by the Assistant Director of Nursing (ADON) on 8/3/11, indicated CNA #3 answered the call light in Resident 41's room. The resident's roommate had turned the call light on for her. The resident had gotten out of bed to walk to the rest room and had fallen. The resident had a personal alarm on her bed that was not clipped to her night gown.<br><br>Review of Nursing Progress Notes dated 8/1/11 at 7:45 a.m., indicated | | Resident #36, the physician was notified of resident blood sugars on 7/28/11 with no new orders, with documentation in clinical record **h.** Resident #2, resident no longer resides in this facility. **2. Identification of others potentially affected deficient practice.** On August 19 th , 2011, 100% audit was conducted by the DON/Unit Managers for residents with (a) safety devices, (b) blood sugar checks, (c) wound dressings, (d) pharmacy recommendations, and daily weights. . On August 15 th , 2011, 100% audit was conducted by the Dietary Manager/DON for residents receiving a nutritional supplements. At this time the facility is in compliance with the above. 3. **systemic changes** On August 18, 2011, In-Service was conducted for nursing staff , Dietary Manager and SSD by Staff Development Coordinator regarding physician notification, blood sugar monitoring, daily weights, nutritional supplements, wound care, and pharmacy consultant reports, safety devices and how to document in clinical record. **4. Quality Assurance** Nursing Administration will monitor residents who receive accu checks, daily weights, wound dressings, along with nursing administration, the dietary manager/designee will audit nutritional supplements by observing 3 meals per week x 4 weeks then 3 meals per month x | |

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| | the resident was found on the floor by the bathroom doorway.<br><br>Review of the Incident Follow up and Recommendation Form provided by the ADON on 8/3/11 indicated CNA #4 arrived at the facility at 4:00 a.m., she then received report. After that, she answered Resident 41's call light. The resident's roommate had placed the call light on for the resident. She entered the room to find Resident 41 on the floor. The immediate action put into place at that time was a bed alarm was placed on the bed.<br><br>Interview with the West Unit Manager on 8/3/11 at 1:00 p.m., indicated the resident did not have a sensory pad alarm to her bed at the time of both falls. The West Unit Manager indicated the alarm box the resident had on her wheelchair and the one on her bed were two different types of alarms. The alarm box on her bed was a clip alarm not a sensory pad alarm. She also indicated at the time, the nurse taking care of the resident was responsible to check to make sure the correct alarms were in place.<br><br>Review of Physician Orders dated 7/16/11 indicated a Complete Blood Count and a Basic Metabolic Panel weekly times three weeks then | | 6 months. Need for audits to continue will be determined thru PI process if <100% compliance is noted at 6 months. Monitoring will be to see if physicians were notified for any parameters outside prescribed order. Fall intervention devices in place. Weights obtained as ordered. Nutritional supplements given as ordered on tray cards. Call light Rounding will be conducted 1x per shift x 4 weeks. Then 2x per week x 4 weeks, then monthly x 3 months then quarterly until 100% compliance is attained and maintained x2 quarters. Unit managers to monitor rounding schedule. The SSD will audit in behavior meeting pharmacy consultant reports x 4 weeks then monthly x 6 months. PI committee to determine if rounding should continue after 2 nd quarter if 100% compliance has occurred **5.** Systemic change/completion date | |

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| | monthly. Review of the Laboratory findings indicated the Complete Blood Count nor the Basic Metabolic Panel were completed weekly for three weeks.<br><br>Interview with the West Unit Manager on 8/2/11 at 2:30 p.m., indicated nursing staff did not complete a requisition for the labs to be completed.<br><br>2. On 8/3/11 at 2:45 p.m., Resident #49 was observed sitting in her room in an arm chair by her bed. At that time, there was an alarm box observed on the side of the chair and it was turned on.<br><br>The record for Resident #49 was reviewed on 8/4/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to, heart failure and dementia.<br><br>Review of Physician Orders dated 6/15/11 indicated sensory pad alarm to bed and stationary chair. Another Physician order dated 6/27/11 indicated sensory pad alarm to wheelchair.<br><br>Nursing Progress Notes dated 7/7/11 at 12:15 p.m., indicated a housekeeper found the resident lying | | | |

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| | on the floor in front of her wheelchair next to her bed.<br><br>Review of the Incident Follow up and Recommendation Form indicated the resident was found on the floor next to her bed. The resident stated she slid out of the wheelchair onto the floor. The pull alarm was not attached and the sensor pad was unplugged.<br><br>Interview with the Director of Nursing on 8/5/11 at 9:10 a.m., indicated the resident's alarms should have been attached to the resident and plugged in.<br>3. The record for Resident #19 was reviewed on 8/4/11 at 8:55 a.m. The resident had diagnoses that included, but were not limited to, diabetes, dementia and hypertension.<br><br>The July 2011 Physician Order Sheet was reviewed. A physician order, dated 5/26/11, indicated to check and record the resident's blood sugar four times a day. A physician order, dated 6/29/10, indicated to check and record blood sugar as needed, if blood sugar is less than 70, give a glass of milk or orange juice and recheck in one hour.<br><br>Review of the July 2011 Medication | | | |

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| | Administration record indicated the resident's blood sugar readings were as follows:<br><br>7/1/11 at 7:30 a.m. = 61<br><br>7/2/11 at 7:30 a.m. = 69<br><br>7/5/11 at 7:30 a.m. = 69<br><br>7/11/11 at 7:30 a.m. = 68<br><br>7/12/11 at 7:30 a.m. = 69<br><br>7/13/11 at 7:30 a.m. = 68<br><br>7/17/11 at 7:30 a.m. = 69<br><br>7/18/11 at 7:30 a.m. = 62<br><br>7/21/11 at 7:30 a.m. = 66<br><br>7/31/11 at 7:30 a.m. = 68<br><br>Review of the nursing progress notes dated 7/1/11 through 7/31/11 and review of the July 2011 Medication Administration Record indicated the resident did not receive a glass of milk or juice when his blood sugar was below 70. Also, the resident's blood sugar was not rechecked in one hour as ordered by the physician. | | | |

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| | Interview with LPN #3 on 8/4/11 at 1:25 p.m., indicated the physician's order was not followed when the resident's blood sugar was below 70.<br><br>4. Resident #4 was observed on 8/1/11 at 11:30 a.m. eating lunch. The resident was not served yogurt.<br><br>The resident was observed during the evening meal on 8/1/11 at 6:05 p.m. She was not served yogurt.<br><br>Interview with LPN #3 on 8/1/11 at 6:05 p.m., indicated the resident did not have yogurt with her dinner meal.<br><br>The resident was observed on 8/3/11 at breakfast. The resident did not have yogurt with her breakfast.<br><br>The resident's tray card was reviewed on 8/3/11 at 9:40 a.m. There were no directions for providing yogurt with the meals listed on the tray card.<br><br>The record for Resident #4 was reviewed on 8/2/11 at 10:55 a.m. There was a physician's order dated 6/22/11 for yogurt three times daily. The nutritional care plan dated 4/25/11 had an intervention that indicated the resident was to receive yogurt three times per day. | | | |

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| | LPN #2 was interviewed on 8/2/11 at 2:45 p.m. She indicated she administered Glucerna (a liquid dietary supplement) to the resident as a dietary supplement. She indicated she did not administer yogurt.<br><br>Interview with the Dietary Manager on 8/3/11 at 2:30 p.m., indicated she had not provided yogurt for the resident at meal times or in between the meals, three times per day, as ordered by the physician.<br><br>5. Resident #26 was observed in bed on 8/2/11 at 2:40 p.m. There was no dressing observed on the resident's left inner heel. Observation of the resident's left inner heel indicated there was a pressure ulcer.<br><br>Interview with the Assistant Director of Nursing, at that time, indicated the resident had a pressure ulcer on his left heel and there was no dressing in place on the pressure ulcer. The Assistant Director of Nursing indicated there had been a blood blister on the area and the blister had broken. She indicated the ulcer was 1 x 1.4 centimeters in size. The area was dark red in color.<br><br>The record for Resident #26 was reviewed on 8/2/11 at 9:30 a.m. An entry in the nursing progress notes dated, 7/28/11 at 1:00 p.m., indicated, "Rec'd (received) new order to L (left) lat (lateral) heel, | | | |

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| | where Res (resident) has soft blood blister 1.7 x 0.8, reddish/purple in color, edges closed, no edema, no c/o (complaint) pain, Rec'd new order for Duoderm (a type of dressing used for the treatment of pressure ulcers). . ."<br><br>The form titled, "Pressure Ulcer Status Record" was reviewed. It indicated there was a deep tissue injury on the left inner heel, first noted on 2/27/11. The areas was 1.7 x 0.8 (centimeters) in size and was purple in color.<br><br>A physician order, dated 7/28/11 at 2:00 p.m., indicated, "Apply Duoderm to left inner heel blood blister. Change q (every) 3 days and prn (as needed) for soilage or dislodgement x 14 days."<br><br>Review of the July 2011 Treatment administration Record indicated the Duoderm was applied to the left inner heel on 7/28/11. There was no documentation the Duoderm was applied to the left inner heel after 7/28/11.<br><br>Interview with LPN #2 on 8/2/11 at 2:45 p.m., who was the nurse in charge of Resident #26 for the day shift on 8/2/11, indicated she was not aware the dressing to the resident's pressure ulcer on his left heel was not in place. She indicated the resident had not received a shower that | | | |

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| | day.<br><br>Interview with the Assistant Director of Nursing on 8/2/11 at 2:50 p.m. indicated the last time the dressing was documented as applied to the resident's pressure ulcer was on 7/28/11. She also indicated the resident did not have a dressing in place as ordered by the physician when observed on 8/2/11 at 2:40 p.m. She indicated the dressing was to be changed every 3 days.<br><br>6. The record for Resident #2 was reviewed on 8/2/11 at 10:30 a.m. The resident had diagnoses that included, but were not limited to, hypertension, anxiety, and congestive heart failure.<br><br>The Pharmacy Consultant Report, with a recommendation date of 5/23/11, was reviewed. The report indicated the resident had received alprazolam (an anti-anxiety medication) 0.75 mg (milligrams) every night since January 1, 2011 for anxiety. The recommendation indicated a gradual dose reduction, perhaps decreasing the medication to alprazolam 0.5 mg every night. The attending physician indicated he accepted the recommendation. He indicated the decreased dose was to be implemented as written. | | | |

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| | Review of the June 2011 and the July 2011 Medication Administration Records indicated the resident received Xanax (trade name for alprazolam) 0.75 mg every night.<br><br>Review of the nursing progress notes dated 5/25/11 through 8/2/11 indicated there was no documentation the physician's order to implement the recommendation, written by the Pharmacist, to decrease the alprazolam was followed.<br><br>Interview with the Social Service Designee on 8/3/11 at 11:00 a.m., indicated she was not aware of the physician's agreement to decrease the resident's dose of alprazolam. She indicated the physician's order to decrease the anti-anxiety medication should have been implemented as recommended.<br><br>The Physician Order Sheet dated 6/4/11 for Resident #2 was reviewed. An order, dated 6/4/11, indicated daily weights were to be obtained. A physician's order, dated 6/4/11, indicated Lasix (a diuretic) 40 mg was to be administered intramuscularly daily as needed for a weight gain greater than 2 pounds.<br><br>Review of the nursing progress notes dated 6/4/11 through 8/2/11, the June | | | |

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| | 2011 and July 2011 Treatment Administration Records, and the resident's weight record indicated the resident was not weighed daily as ordered by the physician.<br><br>Review of the weight sheet indicated there were no weights obtained on 6/16/11, 6/26/11, 6/27/11, 6/30/11, 7/1/11, 7/2/11, 7/4/11, 7/5/11, 7/6/11, 7/17/11, and 7/18/11.<br><br>The weight on 6/9/11 was recorded as 182.2, the weight on 6/8/11 was 179.8, a 2.4 pound weight gain.<br>The weight on 6/13/11 was recorded as 172, the weight on 6/12/11 was 168, a 4 pound weight gain.<br>The weight on 6/25/11 was recorded as 159.2, the weight recorded on 6/24/11 was 151.1, a 8.1 pound weight gain.<br>The weight on 7/14/11 was recorded as 158.6 , the weight recorded on 7/13/11 was 156.1, a 2.5 pound weight gain.<br><br>The June 2011 and July 2011 Medication Administration Records were reviewed. Lasix 40 mg was not administered on 6/9/11, 6/13/11, 6/25/11, and 7/14/11 for the weight gains that were greater than 2 pounds, as ordered by the physician.<br><br>Interview with the Assistant Director of Nursing on 8/4/11 at 1:30 p.m. indicated | | | |

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| | the daily weights were no obtained as ordered by the physician. She also indicated the Lasix was not administered for the 2 pound weight gains as ordered by the physician.<br>7. Resident #36's record was reviewed on 08/01/11 at 4 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.<br><br>The Physician's Recapitulation Orders, dated 08/11, indicated an order, which originated on 06/16/11, to administer a glucometer check (blood sugar check) four times daily, before meals and at bedtime and to call the physician if the blood sugar was less than 60 or more than 400.<br><br>A care plan, dated 06/17/11, indicated the resident was a risk for low blood sugars. The approaches indicated, "...monitor blood sugars per accuchecks (glucometer) per md orders...notify md as needed..."<br><br>The resident's Nurses' Notes, dated 07/28/11 at 3:45 a.m., indicated the resident's blood sugar was 52 and orange juice was given, and after 15 minutes the blood sugar was 74.<br><br>There was a lack of documentation in the resident's Nurses' Notes and MAR to indicate the resident's physician had been | | | |

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| | notified of the low blood sugars.<br><br>During an interview on 08/02/11 at 10 a.m., LPN #1 indicated the physician had not been notified of the low blood sugars. She indicated there was no documentation in the resident's record or on the South Units 24 hour report sheet to indicate the resident's physician had been notified.<br><br>A care plan, dated 07/28/11, indicated the resident had diabetes. The approaches indicated, "monitor accuchecks per md orders...keep md informed as indicated...notify md as needed..."<br><br>The Physician's Recapitulation Orders, dated 08/11, indicated an order, originally written on 03/08/11, to check the resident's blood sugar three times a day and to notify the physician if the blood sugar was less than 60 or more than 400.<br><br>The resident's MAR dated 07/11, indicated the resident's blood sugar at 7 a.m. on 07/12/11 was 48 and the 7 a.m. blood sugar on 07/26/11 was 57.<br><br>There was a lack of documentation on the MAR and in the Nurses' Notes to indicate the resident's physician had been notified of the low blood sugars.<br><br>During an interview on 08/02/11 at 1:50 | | | |

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p.m., the Director of Nursing indicated the physician had not been notified of the low blood sugars.

8. Resident #24's record was reviewed on 08/02/11 at 10:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus.

A care plan, dated 07/28/11, indicated the resident had diabetes. The approaches indicated, "...monitor labs per md orders...notify md as needed...."

The Physician's Recapitulation Orders, dated 08/11, indicated an order, originally written on 03/08/11, to check the resident's blood sugar three times a day and to notify the physician if the blood sugar was less than 60 or more than 400.

The resident's MAR dated 07/11, indicated the resident's blood sugar at 7 a.m. on 07/12/11 was 48 and the 7 a.m. blood sugar on 07/26/11 was 57.

There was a lack of documentation on the MAR and in the Nurses' Notes to indicate the resident's physician had been notified of the low blood sugars.

During an interview on 08/02/11 at 1:50 p.m., the Director of Nursing indicated the physician had not been notified of the low

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| | blood sugars.<br><br>3.1-35(g)(2) | | | |
| F0314 SS=D | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br>Based on observation, record review and interview, the facility failed to ensure pressure ulcer treatments were provided as ordered by the physician for 1 of 3 residents with a pressure ulcer in a sample of 22. (Resident #26)<br><br>Findings include:<br><br>Resident #26 was observed in bed on 8/2/11 at 2:40 p.m. There was no dressing observed on the resident's left inner heel. A pressure ulcer was observed on the resident's left inner heel.<br><br>Interview with the Assistant Director of Nursing, at that time, indicated the resident had a pressure ulcer on his left heel and there was no dressing in place on the pressure ulcer. The Assistant Director of Nursing indicated there had been a | F0314 | **F314 483.25(c) Treatment/SVCS To Prevent/Heal Pressure Sores 1. Corrective action** Resident #26, dressing applied in front of surveyor 8/2/11 and healed out on 8.11.11 **2. *Identification of others*.** On August 19 th 2011 a 100% audit was conducted by the DON/Unit Managers of residents requiring wound care dressings. Residents were found to have Dressing in place 3. **systemic changes** On August 18, 2011, In-Service was conducted for nursing staff regarding wound care dressings by staff development coordinator. **4. Quality Assurance** 100% audit to monitor for residents who require wound dressing changes according to physician orders will be utilized weekly x 6 months by DON, nursing management, or designee. Any non-compliance will be immediately addressed | 08/31/2011 |

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| | blood blister on the area and the blister had broken. She indicated the area was 1 x 1.4 centimeters in size. The area was dark red in color; it was a ruptured blood blister.<br><br>The record for Resident #26 was reviewed on 8/2/11 at 9:30 a.m. The resident had diagnoses that included, but were not limited to, prostate cancer, metastatic cancer to the brain and bone and depression.<br><br>An entry in the nursing progress notes dated, 7/28/11 at 1:00 p.m., indicated, "Rec'd (received) new order to L (left) lat (lateral) heel, where Res (resident) has soft blood blister 1.7 x 0.8, reddish/purple in color, edges closed, no edema, no c/o (complaint) pain, Rec'd new order for Duoderm (a type of dressing used for the treatment of pressure ulcers). . ."<br><br>The form titled, "Pressure Ulcer Status Record" was reviewed. It indicated there was a deep tissue injury on the left inner heel, first noted on 2/27/11. The areas was 1.7 x 0.8 (centimeters) in size and was purple in color.<br><br>A physician order, dated 7/28/11 at 2:00 p.m., indicated, "Apply Duoderm to left inner heel blood blister. Change q (every) 3 days and prn (as needed) for soilage or | | and resolved. The threshold is 100%. Audits x 6 months will be brought to PI for review and evaluation. At that time continuation or discontinue according to 100% threshold will be determined. DON/designee will review new treatments orders and changes M-F during business hours during clinical change of condition meeting<br>**5. By what date the systemic changes will be completed.**<br>**8.31.11** | |

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| | dislodgement x 14 days."<br><br>Review of the July 2011 Treatment administration Record indicated the Duoderm was applied to the left inner heel on 7/28/11. There was no documentation the Duoderm was applied to the left inner heel after 7/28/11.<br><br>Interview with LPN #2 on 8/2/11 at 2:45 p.m., who was the nurse in charge of Resident #26 for the day shift on 8/2/11, indicated she was not aware the dressing to the resident's pressure ulcer on his left heel was not in place. She indicated the resident had not received a shower that day.<br><br>Interview with the Assistant Director of Nursing on 8/2/11 at 2:50 p.m. indicated the last time the treatment for the pressure ulcer was documented as applied to the resident's heel was on 7/28/11. She also indicated the resident did not have a Duoderm dressing in place on the pressure ulcer as ordered by the physician when observed on 8/2/11 at 2:40 p.m. She indicated the Duoderm dressing was to be in place at all times and was to be changed every 3 days.<br><br>3.1-40(a)(2) | | | |

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| F0323 SS=D | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review and interview, the facility failed to ensure residents were free from falls related to bed and chair alarms not used or functioning, for 2 of 15 residents reviewed with bed and/or chair alarms in the sample of 22. (Residents #41 and #49)<br><br>Findings include:<br><br>1. On 8/2/11 at 9:10 a.m., Resident #41 was observed sitting on the side of her bed eating breakfast. At that time, there was no bed alarm observed on the bed.<br><br>The record for Resident #41 was reviewed on 8/2/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, history of falls, stroke, and diabetic neuropathy. The resident was admitted to the facility on 7/16/11 from the hospital.<br><br>Review of Physician orders dated 7/19/11 indicated sensory pad alarm to bed and wheelchair. Check placement and function every shift. | F0323 | **F 323 483.25(h) Free of Accident Hazards/Supervision/Devices**<br>1. **Corrective action accomplished for Resident affected by the alleged deficient practice:** a. Resident #41, this resident no longer resides in this facility. **b.** Resident #49, fall interventions were reviewed and updated on 8.19.2011 **2. Identification of others potentially affected.** On August 19 th 2011 a 100% audit was conducted by the DON/Unit Managers of residents requiring safety devices and residents had devices applied per physician order. 3 **systemic changes** In-Service was conducted for nursing staff regarding safety devices 8.18.11 by staff development coordinator. **4. Quality Assurance** Safety Devices Rounding will be conducted 1x per shift x 6 months by licensed nurses and nursing assistants. Then quarterly until 100% compliance is attained and maintained x2 quarters. Unit managers to monitor rounding schedule.PI committee to determine if rounding should continue after 2 nd quarter of 100% compliance has occurred **5. By what date the systemic** | 08/31/2011 |

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| | Review of the initial Minimum Data Set (MDS) assessment dated 7/29/11 indicated the resident was understood and was able to understand. The resident's vision was highly impaired. The resident's balance during transfers, walking, moving on and off the toilet and surface to surface was not steady. The resident primarily used a wheelchair and walker for ambulation. The resident did have a history of falls in the last month prior to admit and in the last two to six months.<br><br>Review of the Fall Risk Assessment dated 7/16/11 indicated the resident was a high risk for falls. The staff interventions at that time, was a bed and wheelchair pad alarm.<br><br>The current plan of care dated 7/25/11 indicated the resident had a history of multiple falls. The nursing intervention was to place a sensor pad alarm to bed and wheelchair.<br><br>Review of Nursing Progress Notes dated 7/29/11 at 1:00 a.m., indicated the resident was found lying on the floor in front of the bathroom door.<br><br>Review of the Incident Follow up and Recommendations Form provided by the Assistant Director of Nursing | | **changes will be completed.**<br>Date of compliance 8.31.11 | |

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| | (ADON) on 8/3/11, indicated CNA #3 answered the call light in Resident 41's room. The resident's roommate had turned the call light on for her. The resident had gotten out of bed to walk to the rest room and had fallen. The resident had a personal alarm on her bed that was not clipped to her night gown.<br><br>Review of Nursing Progress Notes dated 8/1/11 at 7:45 a.m., indicated the resident was found on the floor by the bathroom doorway.<br><br>Review of the Incident Follow up and Recommendation Form provided by the ADON on 8/3/11 indicated CNA #4 arrived at the facility at 4:00 a.m., she then received report. After that, she answered Resident 41's call light. The resident's roommate had placed the call light on for the resident. She entered the room to find Resident 41 on the floor. The immediate action put into place at that time was a bed alarm was placed on the bed.<br><br>Interview with the West Unit Manager on 8/3/11 at 1:00 p.m., indicated the resident did not have a sensory pad alarm to her bed at the time of both falls. The West Unit Manager indicated the alarm box the resident had on her wheelchair and the one on | | | |

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| | 155287 | A. BUILDING 00<br>B. WING | 08/08/2011 |

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| | her bed were two different types of alarms. The alarm box on her bed was a clip alarm not a sensory pad alarm. She also indicated at the time, the nurse taking care of the resident was responsible to check to make sure the correct alarms were in place.<br><br>2. On 8/3/11 at 2:45 p.m., Resident #49 was observed sitting in her room in an arm chair by her bed. At that time, there was an alarm box observed on the side of the chair and it was turned on.<br><br>The record for Resident #49 was reviewed on 8/4/11 at 10:55 a.m. The resident's diagnoses included, but were not limited to, heart failure and dementia.<br><br>Review of Physician Orders dated 6/15/11 indicated sensory pad alarm to bed and stationary chair. Another Physician order dated 6/27/11 indicated sensory pad alarm to wheelchair.<br><br>Review of the 5/24/11 quarterly MDS assessment indicated the resident was understood and able to understand. The resident used a walker and a wheelchair primarily. The resident had a history of falls since prior assessment with no injury. | | | |

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Review of the current and updated 5/11 care plan indicated the resident was a fall risk due to weakness and episodes of dizziness. The Nursing interventions were to place a sensory pad alarm to the bed and stationary chair.

Review of the Fall Risk Assessment dated 6/24 and 7/7/11 indicated the resident was a high risk for falls.

Nursing Progress Notes dated 7/7/11 at 12:15 p.m., indicated a housekeeper found the resident lying on the floor in front of her wheelchair next to her bed.

Review of the Incident Follow up and Recommendation Form indicated the resident was found on the floor next to her bed. The resident stated she slid out of the wheelchair onto the floor. The pull alarm was not attached and the sensor pad was unplugged.

Interview with the Director of Nursing on 8/5/11 at 9:10 a.m., indicated the resident's alarms should have been attached to the resident and plugged in.

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| | 3.1-45(a)(2) | | | |
| F0406 SS=D | If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br>Based on record review and interview, the facility failed to ensure a speech therapy evaluation was completed as recommended for 1 of 22 residents reviewed for therapy in the sample of 22. (Resident #99)<br><br>Findings include:<br><br>The record for Resident #99 was reviewed on 8/2/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dysphasia (difficulty swallowing) and aphasia (unable to speak). A physician's order dated 8/2/10 and listed on the August 2011 Physician's Order Summary (POS), indicated the resident was receiving a mechanical soft diet.<br><br>A Rehabilitation Services Multidisciplinary Screening Tool dated 11/4/10, indicated a Speech Therapy | F0406 | **F 406 483.45(a) Provide/Obtain Specialized Rehab Services**<br><br>1. **Corrective action**<br>a. For resident #99; The physician was notified on 8.22.11 with new orders to receive a speech evaluation.<br><br>2. Identify<br>On August 19 th 2011 a 100% audit was conducted by nursing management of residents requiring therapy orders. At that time facility was in compliance with orders and recommendations<br><br>**3 A systemic change the facility has made to ensure the alleged deficient practice** | 08/31/2011 |

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| | evaluation was recommended for possible diet change for upgrade to increase independence with activities of daily living and increase quality of life. Based on the evaluation, documentation indicated the resident may potentially benefit from skilled therapy intervention to address deficits in speech-language pathology and an evaluation would be pursued with treatment orders.<br><br>There was no documentation available for review in the resident's record related to a speech therapy evaluation.<br><br>Interview with the Therapy Manager on 8/3/11 at 9:00 a.m., indicated a speech therapy evaluation had not been completed.<br><br>3.1-23(a)(1) | | **does not occur.**<br><br>In-Service was conducted for nursing staff regarding therapy communications 8.18.11. by staff development coordinator Therapy department was in-serviced by Regional director of Therapy Services, on 8.10.2011<br><br>**4.How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur**<br><br>Nursing Administration will monitor therapy recommendations daily thru a therapy folder in the Director of Nursing mailbox. Therapy will place requests for orders in a folder and the Director of Nursing/designee will retrieve requests daily and deliver to the Unit Managers each morning. Requests will be placed on a monitoring tool that will be reviewed during clinical meetings held M-F to see if orders are obtained and communicated to the therapy department.<br>Monitoring will last x 4 | |

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| | | | weeks. Then every 2 weeks x 4 weeks, then monthly x 3 months then quarterly until 100% compliance is attained and maintained x2 quarters. PI committee to determine if monitoring<br>should continue after 2 nd quarter if 100% compliance has occurred<br><br>**5. By what date the systemic changes will be completed.**<br><br>Date of compliance 8.31.11 | |

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| F0431 SS=D | The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>Based on observation, record review, and interview, the facility failed to ensure an accurate account of a controlled drug was maintained and reconciled, related to the amount of Roxanol (Morphine Sulfate) (narcotic pain medication) signed as given and destroyed after a resident was | F0431 | **F 431 483.60(b), (d), (e) Drug Records, Label/Store Drugs & Biologicals 1. Corrective action accomplished for Resident affected by the alleged deficient practice:** Resident #109, the 2 nurses performing drug destruction have were educated by the DON on the proper procedure for drug | 08/31/2011 |

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| | discharged for 1 of 3 closed records reviewed in a sample of 22. (Resident #109)<br><br>Findings include:<br><br>Resident #109's closed record was reviewed on 08/03/11 at 10:40 a.m. The resident's diagnoses included, but were not limited to, dementia and anemia. The record indicated the resident expired at the facility on 06/26/11.<br><br>A physician's order, dated 06/25/11, indicated an order for Roxanol, five milligrams (mg) sublingually (SL) (under the tongue) every hour as needed for pain or respiratory distress.<br><br>A charge form from the facility's Emergency Drug Kit (EDK) indicated a 30 milliliter (ml) bottle of roxanol had been removed from the facility's EDK on 06/25/11.<br><br>The EDK controlled substances kit listing, indicated the roxanol bottle contained 20 mg/ml liquid and there was 30 ml in the bottle.<br><br>The Medication Administration Record (MAR), dated 06/11, indicated the resident should have received 0.25 ml (5 mg) of the roxanol SL every hour as | | destruction and drug reconciliation on 8.19.11 **2. How Facility reviewed all residents who could be affected by the same alleged deficient practice.** A 100% audit was conducted on narcotics and narcotic records. 8.19.11, by the Pharmacy Consultant and the facility is in compliance according to pharmacy consultant review. 3. **A systemic change the facility has made to ensure the alleged deficient practice does not occur.** In-Service was conducted for Licensed Nurses regarding Narcotic tracking and drug destruction. 8.19.11, by the Pharmacy Consultant. **4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur** Nursing Administration will monitor Narcotic Drug Destruction. Monitoring will be conducted weekly to see if the amount of drug dispositioned and the total amount of drug listed on the narcotic count log. Weekly monitoring will last for 4 weeks and if 100% compliance is achieved be reduced to every other week for 4 weeks, if 100% compliance is achieved be reduced to monthly x 4 months. If 100% compliance is achieved the Performance Improvement Committee will review and decide if further monitoring is necessary. **5. By what date the systemic** | |

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| | needed for pain or respiratory distress.<br><br>The MAR indicated the resident received the 0.25 ml (5mg) on 06/25/11 at 11 a.m., 5:45 p.m., 7 p.m., 9:45 p.m., and 11:45 p.m. and 06/26/11 at 1 a.m. and 2 a.m. The amount of the total roxanol given would have been 1.25 ml (35 mg).<br><br>The Individual Resident Control Medication Record Sheet, dated 06/25/11, indicated the starting count of the roxanol was 20 mg. There was 0.25 written underneath the amount remaining and then 19.75 was written under the .25 mg. There was no date written on the amount remaining. There was a lack of documentation to indicate the resident had received seven doses of the roxanol.<br><br>The Drug Disposition Form, dated 07/13/11 and signed by two nurses, indicated 19.75 mg was destroyed in the facility (there should have been 565 mg or 28.25 ml left in the bottle).<br><br>During an interview on 08/03/11 at 1:30 p.m., LPN #3 (one of the nurses who destroyed the medication) indicated she filled out the controlled medication record. She indicated she thought there was 22 ml in the bottle. She indicated the nurses had not signed out the roxanol and was not sure how the nurses were | | **changes will be completed.**<br>Date of compliance 8.31.11 | |

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| | counting the roxanol with shift change.<br><br>During an interview on 08/05/11 at 9:55 a.m., the Director of Nursing indicated she was in the process of investigating the unaccounted roxanol. She indicated there was a 9 ml discrepancy and was unable to determine where the roxanol was because they could not find a missing count sheet. She indicated the nurses who destroyed the medication had not measured the roxanol in a medication cup before destroying the medication. She indicated she had not been notified of the discrepancy.<br><br>A facility policy, dated 01/15/09, titled, "Inventory Control of Controlled Substances", received from the Assistant Director of Nursing as current, indicated, "...The facility should maintain separate individual controlled substance records on all Schedule II drugs...The facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances at least daily or at the change of each shift...the facility should ensure that its staff IMMEDIATELY reports suspected theft or loss of controlled substances to their supervisor/manager..."<br><br>3.1-25(m) | | | |

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| F0502 SS=D | The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>Based on record review and interview, the facility failed to obtain a stool specimen timely for 1 of 22 residents reviewed for labwork in a sample of 22. (Resident #2)<br><br>Findings include:<br><br>The record for Resident #2 was reviewed on 8/2/11 at 10:30 a.m. A physician's order, dated 6/13/11 at 4:30 p.m., indicated to check stools for C-difficile (clostridium difficile a fungal infection that causes diarrhea) x 3.<br><br>Review of the laboratory test results indicated a stool sample was collected on 6/17/11, four days after the physician's order for the stool test was obtained. The stool sample was positive for Clostridium difficile. The physician was notified of the lab results on 6/18/11 and orders for antibiotic treatment were obtained.<br><br>Review of the nursing progress notes dated 6/13/11 at 10:00 p.m. indicated, ". . . loose stools x 4 this evening. . . notified (name of Physician) office at 4:30 p.m. Rec'd (received) n.o. (new order) to check stool for C-diff x 3 . . ." | F0502 | **F 502 483.75(j), (1) Administration**<br><br>**1. Corrective action accomplished for Resident affected by the alleged deficient practice:**<br><br>a. Resident #2, Stool specimen was obtained on 6.17.11.<br><br>**2. How Facility reviewed all residents who could be affected by the same alleged deficient practice.**<br><br>A 100% audit was completed on 8.19.11 by the DON, of residents with lab orders. At time of audit facility in compliance with lab orders<br><br>3. **A systemic change the facility has made to ensure the alleged deficient practice does not occur.**<br><br>In-Service was conducted for Licensed Nurses regarding | 08/31/2011 |

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| | Review of the form titled "Monthly Flow Report"and dated June 2011, indicated the resident had stools x 4 on the evening shift on 6/13/11, 4 stools on 6/14/11, 3 stools on 6/15/11, and 4 stools on 6/16/11.<br><br>Interview with the Assistant Director of Nursing on 8/4/11 at 1:00 p.m., indicated the stool sample was not obtained timely. She indicated the resident had stools on 6/13/11, 6/14/11, 6/15/11 and 6/16/11. She indicated a stool sample should have been obtained prior to 6/17/11.<br><br>3.1-49(a) | | completing lab requisitions and communicating lab orders 8.18.11 by SDC<br><br>**4. How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur**<br><br>Nursing Administration will review new orders and lab order changes in change of condition. M-F lab orders will be placed on a monitoring tool. Monitoring will be conducted to see if orders are noted and placed on the lab communication log. Monitoring will last for 4 weeks and if 100% compliance is achieved be reduced to 3 times per week for 4 weeks, if 100% compliance is achieved be reduced to 1 time per week for 4 weeks. If 100% compliance is achieved the Performance Improvement Committee will review and decide if further monitoring is necessary.<br><br>**5. By what date the systemic changes will be completed.** | |

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| | | | Date of compliance 8.31.11 | |
| F0514 SS=E | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to clarification of advance directive orders, clarification of medication parameters, dietary supplements, clarification of treatment orders and documentation of medication administration for 5 of 22 residents reviewed for clinical records in a sample of 22. (Residents #2, #4, #9, #26, and #75)<br><br>Findings include:<br><br>1. The record for Resident #75 was reviewed on 8/2/11 at 10:50 a.m. The resident was admitted to the facility on 4/9/11. At the time of admission, the resident had an advanced directive of "Do not Resuscitate." | F0514 | **F 514 483.75(l), (1) Records-Complete/Accurate/Accessible** 1. **Corrective action accomplished for Resident affected by the alleged deficient practice:** a. Resident #75, the advanced directives were clarified and corrected on the resident's medical record on 8.2.11 by the Social services Director b. Resident #4, the physician was notified on 8.3.11 and new order obtained to continue Glucerna three times a day. c. Resident #26, .MD notified of podiatrist order and was discontinued per primary physician due to resident on hospice and no need determined at this time for anti-fungal treatment on 8.2.11. d. Resident #2, MD notified of eye drops were not documented on 6.29.11 & 6.30.11. Resident eyes assessed with no redness or complaints of irritation noted. No further orders on 8.18.11. e. Resident #9, MD | 08/31/2011 |

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| | The resident was readmitted to the facility on 7/17/11. The August 2011 Physician's Order Summary (POS), indicated an order was dated 7/17/11 indicating the resident was a "full code."<br><br>An interim care plan dated 7/19/11, indicated the resident's advanced directive was listed as do not resuscitate.<br><br>The social service progress noted dated 7/27/11, indicated the resident was a do not resuscitate.<br><br>Interview with the Administrator on 8/3/11 at 9:00 a.m., indicated a clarification order had been obtained and the resident's current advance directive was full code. | | notified on 8.2.11 to hold lasix and digoxin related decrease in vital signs and level of consciousness. 2. **How Facility reviewed all residents who could be affected by the same alleged deficient practice.** On August 19 th 2011 a 100% audit was conducted of Medication Administration Records, Treatment Administration Records, Advanced Directives, and Dietary Supplements. 3. **A systemic change the facility has made to ensure the alleged deficient practice does not occur.** In-Service was conducted for nursing staff, dietary manager and Staff Development Coordinator regarding Medication Administration/Treatment Documentation. Physician Orders, Dietary Supplements and Advanced Directives on Thursday 8.18.11 by the SDC. 4. **How corrective actions will be monitored to ensure that alleged deficient practice will not reoccur** Nursing Administration will monitor Medication Administration/Treatment documentation, and New Orders for Supplements in addition to nursing administration will also be monitored by Dietary Manager with Change of Condition during clinical meeting M-F. Social Service and nursing Department will monitor Advance Directives during change of condition, | |

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|---|---|---|---|
| | 155287 | A. BUILDING 00<br>B. WING | 08/08/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | 2. On 8/2/11 at 1:55 p.m., Resident #4 was observed in her room. There was a can of Glucerna, a liquid dietary supplement, on the resident's bedside table.<br><br>The record for Resident #4 was reviewed on 8/2/11 at 10:55 a.m. The Interdisciplinary Progress notes were reviewed. A progress note dated 7/8/11 indicated the resident was receiving Glucerna three times a day. A progress note dated 7/28/11 indicated the resident continues to receive Glucerna three times a day.<br><br>Review of the physician's orders dated 7/1/11 through 8/2/11, indicated there was no physician order for Glucerna.<br><br>LPN #2 was interviewed on 8/2/11 at 2:45 | | admission and re-admission process with chart review during clinical meeting M-F. Monitoring will last for 4 weeks and if 100% compliance is achieved be reduced to 3 times per week for 4 weeks, if 100% compliance is achieved be reduced to 1 time per week for 4 weeks. If 100% compliance is achieved the Performance Improvement Committee will review and decide if further monitoring is necessary.<br>**5. By what date the systemic changes will be completed.**<br>Date of compliance 8.31.11 | |

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| | p.m. She indicated she administered Glucerna to the resident as a dietary supplement.<br><br>Interview with the Director of Nursing on 8/3/11 at 8:40 a.m., indicated there was no physician's order for the resident to have Glucerna three times per day.<br><br>3. The record for Resident #26 was reviewed on 8/2/11 at 9:30 a.m. A physician order, written by the podiatrist and dated 6/28/11, indicated the resident was to have Clotramazole 1% cream to his toes and feet daily x 1 week.<br><br>Review of the June 2011 and the July 2011 Treatment Administration Records indicated the treatment was not done as ordered.<br><br>Interview with the Director of Nursing on 8/3/11 at 8:45 a.m. indicated the attending physician did not want the treatment of the Clotramazole to be completed. She indicated the attending physician discontinued the treatment. She indicated there was no written physician order to discontinue the treatment.<br><br>4. The record for Resident #2 was reviewed on 8/2/11 at 10:30 a.m. A physician order, dated 6/28/11, indicated the resident was to receive Gentamycin | | | |

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| | (an antibiotic) eye drops, 2 drops to each eye four times a day for 7 days.<br><br>Review of the July 2011 Medication Administration Record indicated the resident received the eye drops July 1 through July 5, 2011.<br><br>Review of the June 2011 Medication Administration Record indicated there was no documentation the resident received the Gentamycin eye drops on June 29 and 30, 2011.<br><br>Interview with the Assistant Director of Nursing on 8/3/11 at 2:30 p.m. indicated there was no documentation on the June 2011 Medication Administration Record that the resident received the Gentamycin eye drops on 6/29/11 and 6/30/11.<br>5. Resident #9's record was reviewed on 08/02/11 at 2:50 p.m. The resident's diagnoses included, but were not limited to, severe chronic kidney disease and atrial fibrillation.<br><br>The resident's Physician's Recapitulation Orders, dated 08/11 indicated orders for Digoxin (heart medication) 125 mcg (micrograms) daily and furosemide (diuretic) 40 mg (milligrams) daily. The orders were originally written on 10/01/10. | | | |

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| | The Medication Administration Record (MAR), dated 07/11, indicated the Digoxin and the furosemide had been held (circle around the initials), on July 27, 28, 29, and 30, 2011.<br><br>There was a lack of documentation on the MAR and in the resident's Nurses' Notes to indicate why the medications had been held.<br><br>During an interview on 08/03/11 at 8:15 a.m., the Director of Nursing (DoN) indicated the nurse had notified the resident's physician 07/27/11 and had received an order to hold the Digoxin and furosemide due to low pulse and a decline in the resident's condition. The DoN indicated the nurse had not written the order to hold the medication. The DoN indicated she had called the resident's physician on 08/02/11 and had clarified the hold order.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |